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Paper

Aspects of the Psychopathology of Sexual Behaviour

by Professor J P Watson MD FRCPsych,
J M Annear MRCPsych and M Yaffe MPhil
(Guy's Hospital Medical School, London Bridge, London SE1 9RT)

According to Kraupl-Taylor (1966), 'psychopathology' is one of the 'over-long list of psychiatric terms which owe their popularity to their semantic uncertainty'. In this paper, the term 'psychopathology' refers to more than the 'actual conscious psychic events' of Jaspers (1963) and is concerned with describing and explaining – and perhaps also predicting – behaviour (using this word in its broadest sense). Pyschopathology so defined is naturally of interest to the clinician who tries to understand and treat people with sexual problems.

In this paper we shall first indicate elements of a psychopathology of sexuality which seem to us to be important. We shall then discuss in more detail variables which may affect sexual arousal and response; and we will indicate patterns of sexual arousal and of sexual object choice which may occur in persons with gender identity problems. The paper is based upon experience with patients with sexual dysfunctions and with transexualism seen at Guy's Hospital since 1975.

Elements of a Psychopathology of Sexuality (Table 1)

Context

This heading acknowledges that the physical setting, the presence or proximity of other people and the cultural context, are important determinants of sexual behaviour. Inanimate and social environmental factors provide perceptual cues which may divert the attention of a couple from their lovemaking. One of the principles underpinning the 'new sex therapy' is that sexual enjoyment tends to be diminished by anything which distracts from immediate awareness of bodily feelings and is enhanced inasmuch as the subject can attend to or simply be aware of such feelings (*see* for example Kaplan (1974) on 'pleasuring' and 'genital pleasuring'). A similar notion is expressed when a person listening to music says of it 'I am enjoying this'; he is not, but perhaps just has been.

Table 1
Elements of a psychopathology of sexual behaviour

Contextual elements
Inanimate environment
Social environment
Cultural context
Relationship behaviour
Personal elements
Gender identity
Sexual object preferences
Arousal, arousability and drive

Relationship Behaviour

Sexual behaviour is not understandable except as relationship behaviour (unless masturbating behaviour is in question). Such problems as impotence and premature ejaculation are not properties of individuals, but phenomena which typically declare themselves in two person situations. Construing relationships is a complex matter, but we find that a useful starting point in the assessment of a relationship is to focus upon commitment, communication and conflict.

In a couple, mutual commitment is essential if sexual and relationship problems are to be solved. This is because such problem-solving requires personal and behavioural change to which there is resistance – as there is to all changes which may be evoked by psychological treatment – and only mutual commitment can overcome this resistance. Naturally, failure of mutual commitment tends to precede marital breakdown.

Sex therapy is not successful with two people

who cannot communicate reasonably well with each other, and marital therapy often focuses in detail upon eccentricities of communication. It is noteworthy that while communication processes are disturbed in many sexual dysfunctional couples, sexual problems can occur while communication is really not at all bad. Impaired communication and failure of committal can follow from conflicts (usually multiple and of long standing), but relationship problems may arise from conflict even if persons are mutually committed and are communicating with each other. Essential references for the reader who wishes to explore these matters further are Crown (1976) and Skynner (1976).

Personal Elements

Sexual behaviour occurs in a relationship between people in a context, but personal characteristics of those involved are naturally also of relevance. The rest of this paper is concerned with three such personal elements, and their relationships with each other and with other psychopathological elements.

Gender identity: By this is meant 'the sameness, unity, and persistance of one's individuality as male, female, or ambivalent, in greater or lesser degree, especially as it is expressed in self awareness and behaviour' (Money & Ehrhardt 1972). It is the private experience of gender role (which is the public expression of it), which refers to everything a person does which indicates maleness, femaleness or ambivalence to others or to the self.

Sexual object preference: This refers to the kinds of stimulus which evoke sexual responses. The statistical norm is that adults respond sexually to people who are adult and of the opposite sex and gender. Variations on this pattern arise when people respond to non-people (bestiality), non-adults (as to prepubertal children in pædophilia), or to people of the same sex and gender (homosexuality). In addition, the norm is that people respond to whole other people and the anomaly of fetishism arises when people respond to parts of others.

Arousal, arousability and drive: It seems likely that similar sexual arousal and response processes occur, whatever object preferences are involved. These processes have sometimes been referred to by terms such as 'libido', but we find it helpful, following Whalen (1966), to regard 'libido' as unhelpfully imprecise and to talk instead about 'arousal' or momentary level of sexual excitement, and 'arousability', defined by the increments of arousal produced by successive erotic stimuli. These terms aid the understanding of variations in the sexual response cycle (Masters & Johnson 1966) between individuals and within individuals over time.

Sexual Arousal and Response

Arousal, arousability and drive are readily seen to be intimately linked to sexual object preferences. After all, the term 'object preference' refers to things which tend to evoke sexual responses. Within a broad category like 'adult of the opposite sex', persons may respond to more or less specific subcategories. Some men are responsive to a wide range of stimulus persons (women of less than middle age, for example), others to a much narrower band of stimuli (slim white women with red hair and shapely figures, &c.). Sexual responsiveness can be very specific indeed in ordinary people, as in some persons with anomalous sexual preferences, notably fetishism. It is easy to speculate but difficult to find hard data about the determinants of sexual object preferences, including the causes of heterosexuality, of homosexuality and of the paraphilias. Money & Ehrhardt (1972) have drawn attention to the possible importance of imprinting processes in determining sexual object choice.

The following seven headings indicate the wide range of stimulus characteristics which may determine sexual arousal and response, and also emphasize the substantial differences which may exist between people.

Physical attributes: Studies of sexual preferences suggest that within a cultural group there will be general agreement about 'sexual attractiveness', but with additional individual differences (Mathews *et al.* 1972). Stimulus characteristics may generate impressions of beauty and thereby evoke sexual arousal, but ugliness rather than beauty is erotic for some people, while for others impressions of beauty or ugliness seem to contribute little to erotic responsiveness or lack of it.

Adornments: Included here are clothes, cosmetics, jewellery, tattoos and other things which alter the perceived anatomical configuration. Their use is, of course, partly determined by fashions or cultural norms and partly by the nature of sexual ideals – fantasies which are more or less dependent on culture. Adornments may of course be used to diminish erotic effects (breast binding for instance) as well as to enhance them.

Body styles: These contribute substantially to communication about sexual arousal and arousability and about the possiblity of sexual contact. Body style summarizes a person's habitual ways of walking, running, sitting, standing and lying. People move with varying degrees of ease, and

sexual dysfunctions are often accompanied by difficulty in moving easily, let alone enjoyably.

Language: Language which may stimulate sexual arousal ranges from obscene talk to 'sweet nothings'. In some couples, verbalizations during arousal lead to further arousal. In others, no speech occurs during coitus. Sometimes, of course, people make love quietly because they do not wish to disturb children, parents or neighbours; concern about such matters usually inhibits sexual enjoyment.

Fantasies: Some people have a rich sexual fantasy life; others seem to have no fantasies at all. Masturbation may be associated with fantasies, but may occur without any image or conscious fantasy. There are very great differences between people in the extent to which sexual arousal, during coitus and also in other circumstances, is associated with erotic fantasy.

Sexual materials: A wide range of stimuli may evoke sexual responses accompanied by any of numerous emotional reactions – positive, negative or both, including anxiety, fear, anger, pleasure, disgust, curiosity and shame. This heading refers to writing, drawing, painting, sculpture, ceramics and the like; private performances, recorded or spoken; performances for an audience (such as recitations, plays, dances, religious rites); performances in which one is a participant; mechanical sexual aids (e.g. vibrators or penile rings); and even surrogate partners. Pornography is a term often used in this context; it may be defined as material which produces sexual excitement, comprising representations of sexual objects and erotic situations, rather than the objects or situations themselves. The principal uses of sexually explicit materials are to provide images upon which individuals can focus during masturbation or which may potentiate later intercourse.

Taboos: A sense of danger such as can be derived from awareness of the possible consequences of committing an illegal act can lead to sexual excitement. Sometimes, however, a sense of danger leads to anxiety and thereby to impotence.

This is not an exhaustive list, but sufficiently extensive to indicate the range of enquiry required to understand the problems of patients complaining of sexual difficulties.

Aspects of Gender Identity Disorder

We turn now to focus on persons with gender identity disorder. Our aim is to indicate not only that sexual arousal and response are intimately linked with object preferences, as emphasized in the previous section, but that both are closely linked with gender identity. The points to be made here are exemplified from our personal series of fully assessed transexual patients, who at the time of writing are 13 in number.

The typical transexual is the anatomical male of female gender who describes heterosexual attraction toward gender and anatomical males, or the anatomical female of male gender who describes heterosexual attraction toward gender and anatomical females. We have also seen the gender female with male anatomy who describes homosexual attraction for females, but not yet the gender male with female anatomy who wants to relate homosexually to males.

Male to female homosexuals feel they are women, or feel like women or feel they would like to be women. Our patients stress their feminine feelings and behaviour; their relating to others as female, or others treating them as female; or just not being male, or a wish for a new life style.

LH (Case 1), aged 32, desired to be female in relationships. He wanted his physical appearance such that 'people enter relationships with me supposing me to be a woman'. He said 'in this way I feel I am perfectly free to express my own natural tastes, abilities, and values'. TG (Case 2), aged 21, said 'I feel as a woman should feel, I'm emotionally a woman, my mind thinks as a woman, I don't feel masculine at all'. Neatly and with childlike clarity he puts the conflict in a sentence 'I feel like a woman when I'm with someone of my own sex'. The preoccupation can become near delusional. AM (Case 3), aged 44, said 'I wanted to change sex for a couple of years, I'm interested in women's clothing for a long time. I try to act like a woman, I masturbate like a woman with my legs wide open. Can anything be done about my Adam's Apple? My chest is getting bigger, want to see it?'

Several patients took deliberate active steps for many years to oppose their feminine natures. TG (Case 2) signed on in the Army at age 18 mainly to follow his boyfriend of ten years standing, but also to make a man of himself. The Army was not entirely unsuccessful. Now dressing and working as a female 'she' retains multiple body tattoos, attends martial arts instruction and plays snooker, raising 'her' leg and both little fingers in exaggerated female manner when using the cue.

Of our 11 male to female patients, 4 have been married, one of them twice and one thrice; 2 others relate sexually mainly to females, 4 relate to males and 1 to no-one, but in fantasy to males. Both female to male patients relate mainly to females and at present are in stable relationships, one with a common law wife.

Our 13 patients have reported variously deviant object relationships. The male transexual may marry a wife he can identify with, or one with whom he can engage in mutual gender role re-

versal. He may sustain sexual relations, typically with himself in the male inferior position, by transexual fantasy, possibly including fantasy of the wife being the male in the partnership.

Alternatively the male may like women and dislike men, identifying with and wanting sex with women 'as lesbians'. This may be accompanied by a range of sexual experiences. RW (Case 5) has liaised with countless prostitutes for over thirty years and has had 3 or 4 girlfriends; the third was a Swedish divorcee whom he fears he upset by having intercourse with her once. His first relations with prostitutes were straight; later he paid special prices for active followed by passive coitus with a prositute using a dildo. He likes troilism and has occupied middle position on a few occasions. RW wants a sex change to become a lesbian.

Cross dressing is, of course, one of the features of transexualism. All our cases have cross dressed, and at least half of them have, for long periods of time, worn female underwear beneath male top clothing. Garments are sometimes an emotional comfort: TG (Case 2) said 'dressed as a man my feelings go haywire, I feel like hiding in a corner. Even with only one item of female clothing I feel more comfortable emotionally'. As a schoolboy TG took his mother's underwear to school in his satchel for this purpose. Sometimes the importance of cross dressing is mainly a tactile matter – RW (Case 5) has worn tights and knickers ever since asking a prostitute for them twenty years ago. He said 'I feel at home in them, with the feeling of nylon against your skin, fitting against you'. Occasionally cross dressing is associated with erection. GC (Case 4) used to remove his mother's silken underwear from the linen basket; wearing it produced genital arousal.

Cross dressing occurred in the first decade of 9 of our first 12 cases, in the second decade in 2 and in the fourth decade in 2. During childhood and adolescence cross dressing is usually covert and concealed, although it was performed openly in 2 of our cases. Usually cross dressing begins and is continued at the subject's own initiative, but it may be encouraged or even started by the activity of another person, ordinarily female. Mother, sister, girlfriend, acquaintance and prostitute have each been involved in this way with patients. Sooner or later, other people eventually become involved in the transexuals' dressing and 'passing'. Spouses may windowshop with them, advise on clothing and cosmetics, and assist in dressing them. This kind of support seems emotionally important to the transexual, even though he knows the relationship with his wife or ex-wife will end.

Transexuals may be sexually active or inactive. Some wish essentially for the removal of sexuality with reassignment, even if they would not go as far as one of our patients who aspired to a life of 'consecrated virginity'. Others, however, are significantly sexually active and wish to remain so or to become increasingly active. Most patients masturbate to transexual fantasies of possessing a female body, often in the image of spouse, female acquaintance, or magazine picture. Some patients have fantasies which involve masochistic or other paraphilic activity. One reported the logically inconsistent experience of orgasm with ejaculation to the fantasy of having the penile organ removed. Some patients report penile pleasure even when stimulated by transexual fantasy; others locate their pleasure in perineum or anal region.

It is clear that, in order to understand the transexual and 'his' sexual behaviour, the clinician must attend both to the behaviour and to the transexual and 'his' own view of it. The observer must attend also to the behaviour of the transexual's partner and to 'her' view of it. One male to female described a sexual relationship with a female to male patient which would have looked to a third party like ordinary coitus but which was satisfying to the participants because each could enjoy the fantasy of being the other, knowing of the other's fantasy.

Comment

This is a paper which attempts to provide a framework for approaching problems in an area where clinicians sometimes feel that they lack such a framework. We have listed some of the environmental factors which can contribute to erotic experience and described some aspects of transexualism to indicate ways in which personal factors can also contribute to erotic behaviour. We have emphasized that in order to understand sexual problems it is necessary to be able to enquire into very specific details of most intimate activities.

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